May 23, 2012

Áron Boros, Commissioner
Massachusetts Division of Health Care Finance and Policy
Two Boylston Street, 5th Floor
Boston, MA 02216

RE: *Responses to Questions from Division of Health Care Finance and Policy and Attorney General*

Dear Commissioner Boros:

On behalf of Blue Cross and Blue Shield of Massachusetts (BCBSMA), we are pleased to provide the following responses to the Division of Health Care Finance and Policy (the Division) and Attorney General's questions posed in Exhibits B and C respectively in a letter dated May 9, 2012.

Below are detailed responses to the Division's and the Attorney General's questions.

Division of Health Care Finance and Policy Questions

Trends in Premiums and Costs

1. After reviewing our preliminary cost trends reports for 2012, please provide commentary on any finding that differs from your organization's experience.

BCBSMA Response:

The findings highlighted in the Premium Analysis section of the preliminary cost trends reports issued by the Division are consistent with BCBSMA's experience.

In general, as pointed out in the preliminary cost trends report, premiums trends are greatly influenced by trends in total medical expenses (TME). In addition to the drivers

AGO Question 2
Exhibit C
Total Membership

a. Membership by Market Segment

Market Segment Cat.	Dec11	Dec10	Dec09	Dec08
Individuals	30,340	35,512	43,519	40,861
Small Group	236,442	268,867	323,247	375,068
Large Group (incl labor)	1,827,012	1,870,098	1,885,216	1,918,973
Medicare	277,992	273,128	279,011	279,247
Other Government (incl FEP, MSP, Municipal, MIIA)	378,943	382,985	393,140	399,250
	2,750,729	**2,830,590**	**2,924,133**	**3,013,399**

b. Membership whose care is reimbursed through a risk contract (AQC)

Market Segment Cat.	Dec11	Dec10	Dec09	Dec08
Individuals	14,487	16,299	17,268	7,526
Small Group	126,934	142,391	146,592	78,928
Large Group (incl labor)	415,510	432,215	398,368	198,598
Medicare	5,532	5,088	4,026	2,299
Other Government (incl MSP, Municipal, MIIA)	137,618	130,879	106,583	50,512
	700,081	**726,872**	**672,837**	**337,863**

* membership is re-stated

c. Membership by Market Segment and Product Line

Market Segment Cat.	product line	FA	Dec11	Dec10	Dec09	Dec08
Individuals	HMO/POS	INS	29,072	33,874	41,305	37,5
	PPO/Indemnity	INS	1,268	1,638	2,214	3,3
Small Group	HMO/POS	INS	229,874	259,779	306,158	333,5
	PPO/Indemnity	INS	6,568	9,088	17,089	41,4
Large Group (incl labor)	HMO/POS	INS	418,589	423,932	456,362	492,7
		ASC	299,992	338,043	329,743	329,5
	PPO/Indemnity	INS	189,524	190,692	192,824	196,2
		ASC	918,907	917,431	906,287	900,4
			2,093,794	**2,174,477**	**2,251,982**	**2,334,9**

AG, Question 1
Exhibit B
Annual Premium Trend Drivers

	2009	2010	2011	2012*
Unit Cost Trend	5.0%	5.2%	4.0%	3.3%
Utilization Trend	2.3%	2.5%	2.6%	2.1%
Severity Trend	0.4%	0.4%	0.4%	0.4%
Provider Mix Trend	1.9%	2.0%	2.1%	1.7%
Benefit Buy Down	-4.1%	-3.6%	-3.3%	-1.7%
Administrative Expense Trend	0.0%	-0.4%	0.3%	0.1%
Contribution to Reserve Trend	0.1%	-0.2%	-0.4%	0.1%
Other	-2.5%	-1.1%	-0.4%	-2.8%
Premium Trend	2.9%	4.7%	5.2%	3.1%

Note: Current 2013 estimated increases are consistent with 2012

DHCFP, Question 8
Exhibit A

		Use of measure					
Measure Name	Measure Developer	P4P HPIP 10/1/2011	P4P AQC 1/1/12	Tiered Products 1/1/2013	P4P PCPIP	Public Reporting	Marketing
HOSPITAL							
AMI-1 Aspirin at arrival	CMS	x	x				
AMI -2 Aspirin Prescribed at Discharge	CMS	x	x	x			
AMI-3 ACE/ARB for LVSD	CMS	x	x				
AMI-4 Adult Smoking Cessation Advice/Counseling	CMS	x	x				
AMI-5 Beta Blocker Prescribed at Discharge	CMS	x	x				
HF-1 Discharge instructions	CMS	x	x	x			
HF-2 Evaluation of LVS function	CMS	x	x	x			
HF-3 ACE inhibitor or ARB for Left Ventricular Systolic Dysfunction	CMS	x	x	x			
HF-4 Adult Smoking Cessation Advice/Counseling	CMS	x	x				
PN-2 Pneumococcal Vaccination	CMS	x	x				
PN-3b Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Received in Hospital	CMS	x	x	x			
PN-4 Adult Smoking Cessation Advice/Counseling	CMS	x	x				
PN-5c Timing of Initial Antibiotic Following Hospital Arrival - 6 Hours	CMS	x	x				
PN-6 Initial Antibiotic Selection for CAP in Immunocompetent Patient	CMS	x	x	x			
PN-7 Influenza Vaccination	CMS	x	x				
SCIP-Inf-1 Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision	CMS	x	x	x			
SCIP-Inf-2 Prophylactic Antibiotic Selection for Surgical Patients	CMS	x	x	x			
SCIP-Inf-3 Prophylactic Antibiotic Discontinued Within 24 Hours After Surgery End Time	CMS	x	x	x			
SCIP-Inf-4 Cardiac surgery Patients with Controlled 6AM Postoperative Blood Glucose	CMS		x				
SCIP-Inf-9 Urinary Catheter Removed on POD 1 or POD 2 with day of Surgery being Day Zero	CMS	x	x	x			
SCIP-VTE-1 Surgery Patients with recommended Venous Thromboembolism Prophylaxis Ordered	CMS	x	x	x			
SCIP-VTE-2 Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxis Within 24 Hours Prior to Surgery to 24 Hours After Surgery	CMS	x	x	x			

SCIP-Card-2 Surgery Patients on Beta-Blocker Therapy Prior to Arrival Who received a Beta-Blocker During the Perioperative Period	CMS	x	x	x			
OP-6 Timing of Antibiotic Prophylaxis	CMS	x		x			
OP-7 Prophylactic Antibiotic Selection for Surgical Patients	CMS	x		x			
Communication with Nurses	CMS	x	x	x			
Communication with Doctors	CMS	x	x	x			
Responsiveness of Staff	CMS	x	x	x			
Discharge Information	CMS	x	x	x			
PSI 07 Central Venous Catheter Associated Bloodstream Infections	AHRQ	x	x	x			
PSI 12 Post-operative Pulmonary Embolism or Deep Vein Thrombosis	AHRQ	x	x	x			
PSI 19 OB Trauma - Vaginal without Instrument	AHRQ	x		x			
PSI 18 OB Trauma - Vaginal with Instrument	AHRQ	x		x			
PSI 11 Post-operative Respiratory Failure	AHRQ	x		x			
PSI 15 Accidental Puncture or Laceration	AHRQ	x		x			
PSI 6 Iatrogenic Pneumothorax, Adult	AHRQ	x		x			
IQI 15 Mortality AMI	AHRQ	x					
IQI 17 Mortality Acute Stroke	AHRQ	x					
Acute Myocardial Infarction After Major Surgery	WebMD (former HCUP measure)	x	x				
Pneumonia After Major Surgery/Invasive Vascular Procedure	WebMD (former HCUP measure)	x	x				
Wound Infection Rate	WebMD (former HCUP measure)		x				
AMBULATORY							
Depression							
Acute Phase Rx	HEDIS		x		x		
Continuation Phase Rx	HEDIS		x		x		
Diabetes							
HbA1c Testing (2X)	HEDIS		x	x	x	x	
Eye Exams	HEDIS		x	x	x	x	
Nephropathy Screening	HEDIS		x	x	x	x	
Cholesterol Management							
Diabetes LDL-C Screening	HEDIS		x	x	x	x	
Cardiovascular LDL-C Screening	HEDIS		x	x	x		
Cancer Screening							
Breast Cancer Screening	HEDIS		x	x	x	x	
Cervical Cancer Screening	HEDIS		x	x	x	x	
Colorectal Cancer Screening	HEDIS		x	x	x		
Preventive Screening/Treatment							
Chlamydia Screening							
Ages 16-20	HEDIS		x	x	x		
Ages 21-24	HEDIS		x	x	x		
Adult Respiratory Testing/Treatment							
Acute Bronchitis	HEDIS		x		x		
Pedi: Testing/Treatment							

Upper Respiratory Infection (URI)	HEDIS		x	x	x		
Pharyngitis	HEDIS		x	x	x		
Pedi: Well-visits							
< 15 months	HEDIS		x	x	x	x	
3-6 Years	HEDIS		x	x	x	x	
Adolescent Well Care Visits	HEDIS		x	x	x	x	
Diabetes							
HbA1c in Poor Control (>9)	HEDIS		x		x		
LDL-C Control (<100mg)	HEDIS		x		x		
Blood Pressure Control (130/80)	HEDIS		x		x		
Hypertension							
Controlling High Blood Pressure (140/80)	HEDIS		x		x		
Cardiovascular Disease							
LDL-C Control (<100mg)	HEDIS		x		x		
Effeciency							
Lab effeciency: rewards physicians for the percentage of outpatient lab tests performed at low-cost lab sites (independent labs, physician offices, some hospitals).	BCBSMA claims				x		
Access to Care - attestation measure to ensure that members have adequate and timely access to PCPs	Attestation				x		
Generic Prescriptions: rewards physicians for their generic prescribing rate or generic rate of prescriptions for their members compared to the Network Average. Adult and Pediatrics are calculated separately for this measure.	BCBSMA claims				x		
Patient Experiences - Adult							
Communication Quality	C/G CAHPS/ACES		x	x			
Knowledge of Patients	C/G CAHPS/ACES		x	x			
Integration of Care	C/G CAHPS/ACES		x	x			
Access to Care	C/G CAHPS/ACES		x	x			
Patient Experiences) - Pediatric							
Communication Quality	C/G CAHPS/ACES		x				
Knowledge of Patients	C/G CAHPS/ACES		x				
Integration of Care	C/G CAHPS/ACES		x				
Access to Care	C/G CAHPS/ACES		x				

AG, Question 1
Exhibit B.1

(Please Refer to Exhibit B separately attached)

Narrative to AG Question 1

Unit cost: This component of trend represents the increase in the cost of services. More specifically these are the annual increases for specific services, like an office visit or a hospital admission, most often negotiated with the providers of care. Drivers of the unit cost increases include the high cost of living and labor expenses, investments in e-technology, and cost shifting to private payers from public payer shortfalls. Over recent years, we have worked collaboratively with doctors and hospitals to implement more modest payment increases, at levels that allow them to continue to provide the care our members need while also being responsive to the community's urgency about affordability.

Utilization trend: This component of trend can be defined as the increase in the number of services or units of service provided over a period of time. Examples of units of service are the number of inpatient admissions, office visits, Emergency room visits, and lab or diagnostic services. Drivers of changes in the utilization of health care services include aging and deteriorating health status of the population and consumer demand for services. BCBSMA has implemented various chronic disease management, utilization management, wellness and prevention, and care management programs over the past few years to address this trend. Additionally, BCBSMA has launched several new products including consumer directed health plans and tiered network offerings coupled with transparency tools that provide incentives to members to make informed choices about seeking care with high quality, low cost providers..

Severity: This component of trend represents the increase in the intensity of services provided. Increases in this component of trend result from services shifting from lower cost settings to higher cost settings. Major drivers of changing intensity of services include provider adoption of new technology or services as well as consumer demand for those more expensive high tech services.

Provider Mix: This component of trend represents the shift in the setting where medical services are provided. Drivers of provider mix include consumer demand, expansion of capacity in more expensive settings and physician practice patterns.

Benefit Buy Down: This component of trend represents the value of benefit changes that employers make. When employers change benefits, they most frequently switch to less rich benefit plans in order to reduce their underlying health care costs. Drivers of the magnitude of benefit buy down include, but are not limited to, the employer's price sensitivity, the level of underlying medical trend, opportunities to customize benefits, and the resources an employer might have available to change benefit systems quickly. The

level of benefit buy down impact on BCBSMA premiums has mitigated steadily since 2010 as underlying medical trend has come down.

Administrative Expenses: The 10 cents of every premium dollar that covers administrative costs include salaries and benefits of our employees, technology investments, and a wide range of care management programs for our members. Blue Cross and Blue Shield of Massachusetts has continuously expanded and enhanced our wellness and disease management programs to improve the health of our members and the affordability of health care. Some components of administrative expenses such as broker commissions increase at the rate of premium.

Contribution to Reserves (CTR): The National Association of Insurance Commissioners has developed a metric called Risk Based Capital (RBC) to evaluate a company's reserves in light of its membership size and relative risk of its business. We manage our business to maintain RBC between 550-650% in accordance with parameters set by our Board of Directors. CTR targets include risk margins built into the premiums as protection to cover potential risks (operating, strategic, catastrophic, and regulatory). This component of premium also includes taxes (federal income tax and premium tax), where applicable. CTRs primarily increase at the rate of premium trend. Other drivers of the change in CTR targets over time include changes in benefit distribution across the book of business, updates to the CTR levels based on projected risks and RBC levels, and the impact of strategic business decisions.

All other: This component includes the impact of changes in the mix of business and demographics. This also includes the variance between actual components of premiums and projected pricing assumptions.

of premium trend noted below, please refer to BCBSMA's responses to Questions 5 and 11 for underlying drivers of TME and premium increases:

- Overuse of medical services: Overuse of certain services increases costs unnecessarily. Examples include preventable hospital re-admissions and emergency room visits for avoidable or ambulatory sensitive conditions.

- Severity: Increase in trend resulting from services shifting from lower cost settings to higher cost settings. Major drivers of changing intensity of services include provider adoption of new technology or services as well as consumer demand for those more expensive high tech services.

- Regulatory and legislative changes: Regulatory and legislative actions impact costs and trends, such as mandates and assessments on insurers. One example of recently implemented mandates that resulted in increased cost is the expansion of women's preventive services covered at no cost sharing. This resulted in premium increases of approximately 0.5% for the small group segment. Other examples include state and federal health insurer assessments, including assessments to fund the state vaccine program as well as the Patient Centered Outcome Research Institute. Additionally, new mandated benefits also drive up health care costs and premiums.

BCBSMA has the following comments on the findings highlighted in the Statewide Total Medical Expenses results section of the preliminary cost trends report.

- The report places full value on relative TME for groups of any size and cuts a bright line at 1.00 to call a group high cost or not. We would apply a confidence interval based on the group's size before calling a group efficient, inefficient, or average. For BCBSMA TME data, 12 of the 36 groups reported in 2010 would be deemed "average" according to this method, instead of characterizing them as efficient or inefficient.

- The measure of disparity should also use this confidence interval concept. A smaller group with a high TME may be due to random fluctuation. We also would recommend a more robust measure such as interquartile range or 10-90th percentile range instead of the min to max range used in the report.

2. Please comment on the increasing prevalence of benefit buy-down and cost-shifting to members.

BCBSMA Response:

BCBSMA experienced a significant increase in benefit buy-down activity in 2009 and 2010 across all insured market segments. When employers change benefits, they most frequently switch to less rich benefit plans in order to reduce their underlying health care costs. Drivers of the magnitude of benefit buy down include, but are not limited to, the employer's price sensitivity, the level of underlying medical trend, opportunities to

customize benefits, and the resources an employer might have available to change benefit systems quickly. The level of benefit buy down impact on BCBSMA premiums has mitigated steadily since 2010 as underlying medical trend has come down.

Additionally, BCBSMA has tiered offerings, Blue Options and Hospital Choice Cost Sharing, discussed in more detail below. Our tiered offerings have premiums that are significantly lower than premiums for comparable plans that are not tiered. Tiered offerings provide members with incentives to make informed choices about the quality and cost of health care services and are part of the overall BCBSMA strategy to lower health care expenditures and trends. There has been tremendous growth in these offerings over the past few years which is another driver of the increasing prevalence of benefit buy-down.

3. We understand that certain provider systems demand higher rates because of geographic isolation, specialty practice, and reputation. Please explain your understanding of this dynamic and how recent shifts in provider group acquisitions may have influenced this dynamic over the past year.

BCBSMA Response:

The recent provider consolidation seen in the Massachusetts marketplace is not a new phenomenon. Since the 1990s when there were 111 independent acute care hospitals in Massachusetts, the provider landscape has changed dramatically. Hospital mergers and closings have left approximately 70 hospitals and many physicians have joined with each other to form independent physician associations (IPAs), or with hospitals to form physician-hospital organizations (PHOs) or other integrated delivery systems.

Within the past year, we have seen consolidations continuing and taking various shapes, including some independent practices going into large groups, and reconfigurations within large systems. From our perspective provider consolidation is favorable to the marketplace when the following conditions are met: we have multiple networks in every market; there are aligned incentives between payers and providers and the government; consolidation is to promote competition on cost and quality; and consolidation promotes integration and coordination of care. When consolidation is just to increase fee-for-service rates, it is not favorable.

Provider consolidation can provide potential benefits to the system, such as increased integration and coordination of care. However, our experience historically shows that most often, provider consolidation and the resulting market leverage of larger providers has led to increased prices, while very little of the intended integration of care achieved. Our response to this dynamic is to expand both the presence of the Alternative Quality Contract (AQC) across our provider network, and to develop innovative benefit options for employers. Both strategies create meaningful incentives for providers and patients to become engaged in reducing the total cost of care.

AQC providers are accountable for the cost of all care their patients receive, whether the care is delivered by a member of the AQC group or not. As a result, primary care providers have an incentive to look for specialists and facilities that provide high quality at a lower cost, so the AQC has the potential to drive value throughout the system. The AQC, together with new health insurance offerings that create strong incentives for members to choose high-value care, lead members to be active participants in discussions with their health care providers. One example is our Hospital Choice Cost Sharing offering, in which the amount members pay for certain services depends on the hospital and affiliated facilities they choose. These and similar offerings align member incentives with the physician incentives in the AQC to create stronger support for delivery system change.

4. When calculating Total Medical Expense (TME), we found wide variation in health-status adjusted TME by provider group and that a large portion of patient volume is clustered in the most expensive quartile(s) of providers. Please share your organization's reaction to these findings.

BCBSMA Response:

We do expect some amount of variation in health-status adjusted TME among groups. Through the contract negotiation process, a larger organization is able to use its leverage on health plans due to the significant impact that its departure from the provider network would have on current insured members. This potential disruption, and the resulting difference in fee-for-service prices, becomes one factor that can impact TME. This variation can also be attributed to additional factors such as: geography of the provider and alternatives in the area, socioeconomic factors of patient panels, referral patterns, availability of servicing providers, health status of the patients, effectiveness in managing patient care, high concentration of members living in urban areas and in these providers' service area, and variations in cost of living across the state.

In the near-term, our tiered member offerings—specifically Blue Options and Hospital Choice Cost Sharing—are trying to engage our members to choose high-value providers and reduce the volume of patients seeking care from the most expensive providers.

For the longer-term, the AQC model is designed to lower the rate of TME increase over time. Results after year two of the contract show that the AQC continues to reduce the rising cost of care. In 2009, medical spending among AQC groups grew more slowly than non-AQC providers, outperforming non-AQC providers by approximately 2%. In 2010 we saw a deepening of those savings, generated in key areas such as:

- **Reduced inpatient admissions:** By emphasizing better chronic care and follow-up, the 2010 AQC trend for hospital admissions was more than 2% lower than for non-AQC providers. That equates to over 300 avoided admissions, and the complications

that often arise during inpatient stays. It also saved an estimated $6 million in costs associated with those avoided admissions.

- **Improved use of high tech radiology (MRI, CT scans, etc.):** AQC providers better managed the use of high tech radiology, protecting patients from unnecessary and potentially harmful radiation exposure. This represents protecting patients from more than 1,500 unnecessary scans and an estimated $2 million in avoided costs.
- **Using less costly settings for care:** AQC groups continue to refer care to high-quality, lower-cost facilities, particularly for basic tests and procedures, such as outpatient radiology, lab tests and surgical services. These changes resulted in approximately $2.5 million in savings in 2009 and 2010.

5. Please explain the main factors for your plan's TME growth over the past year. What will your company do to try to reduce the growth in TME for next year? In which areas of TME will your organization try to reduce growth?

BCBSMA Response:

Primary drivers of health care trend are:

Unit cost: This component of trend represents the increase in the cost of services. More specifically these are the annual increases for specific services, like an office visit or a hospital admission, most often negotiated with the providers of care. Drivers of the unit cost increases include the high cost of living and labor expenses, investments in e-technology, and cost shifting to private payers from public payer shortfalls. Over recent years, we have worked collaboratively with doctors and hospitals to implement more modest payment increases, at levels that allow them to continue to provide the care our members need while also being responsive to the community's urgency about affordability.

As discussed above in Question 4, the AQC provides incentives to analyze and improve many drivers of health care trend, including utilization trend, severity, and provider mix. These additional drivers of trend are discussed in more detail below:

Utilization trend: This component of trend can be defined as the increase in the number of services or units of service provided over a period of time. Examples of units of service are the number of inpatient admissions, office visits, Emergency room visits, and lab or diagnostic services. Drivers of changes in the utilization of health care services include aging and deteriorating health status of the population and consumer demand for services. BCBSMA has implemented various chronic disease management, utilization management, wellness and prevention, and care management programs over the past few years to address this trend.

Severity: This component of trend represents the increase in the intensity of services provided. Increases in this component of trend result from services shifting from lower cost settings to higher cost settings. Major drivers of changing intensity of services

include provider adoption of new technology or services as well as consumer demand for those more expensive high tech services. Existing BCBSMA medical policies are being reviewed to ensure that they are current and relevant. Coverage of new technology and treatments also undergoes a thorough review and analysis by experts

Provider Mix: This component of trend represents the shift in the setting where medical services are provided. Drivers of provider mix include consumer demand, expansion of capacity in more expensive settings and physician practice patterns. BCBSMA has launched several new products including consumer directed health plans and tiered offerings coupled with transparency tools that provide incentives to members to make informed choices about seeking care with high quality, low cost providers

As indicated in the preliminary cost trends report, macroeconomic factors like the recent economic recession have impacted health care trends as utilization of health care services have decreased throughout 2010 and early 2011 due to loss of employer sponsored coverage and delay of discretionary and preventive services. Primary driver of increased utilization in 2010 and 2011 is increases in ambulatory services spread across many outpatient service categories.

6. How does your organization measure the overall cost of care provided to patients within a given physician group or population, and how is that data applied in performance-based reimbursement arrangements?

BCBSMA Response:

We use TME as the basis for the AQC, which is now our predominant pay-for-performance mode for our HMO population. The historic TME for a group's patient population serves as the starting point from which their global budget is established. As we evaluate the TME for each of these provider groups across the network, region, and other similar organizations, the comparison is used to inform other aspects of our contractual relationship, inclusive of budget trends.

In addition to TME, we also use many different data points to assess physician contracts and proposed reimbursement levels. These sources aid in our efforts to solidify multi-year agreements that include performance measures focused on quality and efficiency improvements, with reimbursement rates determined relative to the value returned to our accounts and members. Some of the data elements used in this process are:

- Peer group cost and rate comparisons
- Comparisons to Medicare Reimbursement rates
- Past claims experience and performance on quality programs or measures
- Industry-wide analysis and reports
- Risk-adjusted, per-member per-month, total medical expense amounts compared to the overall network average

Health System Integration

7. Please comment on how your organization is encouraging the integration of health care providers in global contracts or other alternative payment arrangements.

BCBSMA Response:

Under the AQC model, an organization's financial success is highly dependent upon efficiently managing a patient's care across the continuum of services, while maintaining a focus on the quality of care. The PCP is in the driver's seat, coordinating all care for the patient. As a result, strong integration is essential.

BCBSMA currently has 75% of our HMO membership with a primary care physician in an AQC arrangement. As we built to this level of AQC adoption, BCBSMA has also increased our support capabilities for these AQC groups, offering consultative support from medical directors and clinicians, data and actionable reports, best-practice sharing and collaboration opportunities, and communications and training. BCBSMA's AQC support staff work collaboratively with groups to identify opportunities for quality improvement and cost-savings and to apply best practice theory—leading to an increased level of integration across the provider system.

We have consistently heard from physician leaders, primary care providers, and specialists at all types of AQC groups, large and small, that the global payment model is enabling sustainable changes in the way groups and individuals practice. Among the most common themes: 1) the AQC's aligned quality and efficiency incentives create an environment where there is much more communication, coordination, and integration between primary care providers and specialists, and between physician groups and participating hospitals; 2) more attention is paid to quality indicators, transitions of care, preventable complications, and variations in practice related to overuse, underuse, or misuse of tests and procedures; 3) resources are available to build new infrastructure and information systems, to employ more nurses and medical assistants, and to offer patients preventive care, rehabilitation care, and consultation about medication use; and 4) as one AQC physician leader put it: "Our physicians spend much more time than in the past trying to help patients get their care in the most appropriate setting, and explaining to patients what they want them to do and why."

Right now, our AQC is limited to HMO. However, we are considering whether we can extend this payment methodology to our PPO business. We hope that, as other payers, including the government, move from fee-for-service to global payment, providers will experience a tipping point where they can make these positive changes in how they care for all their patients.

Health Care Quality

8. What quality measures does your organization use to evaluate provider performance in quality-based payment arrangements? Please report this in the format specified by the attached table. You may use the Quality Measurement Catalog, which contains a comprehensive listing of quality measures in use by various organizations nationally, available on the Statewide Quality Advisory Committee website (www.mass.gov/dhcfp/sqac) for reference.

BCBSMA Response:

Please see Exhibit A.

The goal of our performance measurement strategy is to advance care to our end-state vision of safe, affordable, effective, quality patient-centered care. We have three primary pay-for-performance programs: Hospital Performance Improvement Program (HPIP), the AQC, and Primary Care Provider Improvement Program (PCPIP). Currently, 95% of hospitals and 95% of PCPs in our network participate in quality based payment arrangements. For each of these programs, we use quality measures that are nationally accepted, reliable, and valid for payment purposes. Providers receive reports on a regular basis to monitor and improve their performance. The measures we use for each program complement one another so that transitions from our single-site improvement programs to the more comprehensive AQC will occur seamlessly.

HPIP: Our HPIP program measures and rewards performance for all hospitals in our network based on their outcomes. Currently, we have 55 hospitals in HPIP and of these, 14 hospitals are also in the AQC. Under HPIP, hospitals have the potential to earn a prospective incentive payment based on the level of performance above the minimum threshold in each component of the measurement program – outcome, process, and patient experience.

PCPIP: Our PCPIP program measures and rewards outcomes for primary care providers that do not participate in the AQC. PCPIP uses a set of outcomes measures aligned with the AQC. The program has changed over time as the quality measure set has expanded and focused more on outcomes of care versus process of care.

AQC: The AQC measures and rewards performance for hospitals, specialists, and primary care providers who participate in the AQC contract. There are currently 17 medical groups participating in this program. The outcome measures are weighted three times more than process or patient experience measures to signal the importance of these measures. We believe that the AQC is the most comprehensive performance measurement incentive program in the nation.

More recent AQC groups are monitored on their performance on quality in two ways. First, the provider group's quality score drives the amount of shared savings or deficit share for which they are eligible. This link was derived in order to encourage a more holistic approach to improving both quality and efficiency. Second, payment for the quality measures is now made on a per member per month (PMPM) basis. The PMPM

approach means that AQC providers who achieve a given level of performance will be rewarded equally for that performance.

9. What are the specific areas of care for which you believe there are critical gaps in quality measurement?

BCBSMA Response:

As stated in Question 8, we believe strongly that quality measures for payment purposes must be national standards of measurement. Outcomes of care and specialist quality are two areas that are critical gaps in measurement, largely due to the lag in the national endorsement of these types of measures. BCBSMA is monitoring the evolution of outcomes measures through the National Quality Forum and the Patient Centered Outcomes Research Institute, and at the Centers for Medicare and Medicaid Services (CMS). With the development and endorsement of outcome and specialist quality measures, BCBSMA would be able to better align incentives for all provider types and therefore, payment, with the actual value of care.

10. What methods, if any, does your organization use to encourage consumers to use high-value (high-quality, low-cost) providers? What has been the effectiveness of these actions? Please explain and submit supporting documents that show what affect, if any, limited network or tiered products have had on premium trend.

BCBSMA Response:

BCBSMA aligns the incentives it uses in its provider relationships with the incentives offered to members to encourage both the delivery and the receipt of high-value care.

On the member side, we couple benefit designs with member decision-support tools to encourage consumers to use high-value providers, specifically through Blue Options (our tiered offering) and Hospital Choice Cost Sharing (HCCS), our cost-sharing offering . Our tiered offering benefit stratifies primary care physicians and hospitals into three levels based on cost and quality. Member cost sharing varies for each tier: members have the lowest cost sharing when they see lower cost, high quality providers and higher cost sharing when they see providers that are higher cost and lower quality. The HCCS benefit feature is designed to offer better value for members and accounts by encouraging the use of high-quality care that is less costly. HCCS offers members lower copays when they receive services at facilities that are high-value, as determined through the same methodology as the tiered benefit. This design also supports our overall affordability goal by creating a strong incentive for hospitals to lower their fees and increase quality. Each of these offerings results in an estimated premium discount of about five percent, relative to products with comparable benefits. Lastly, we offer many consumer-driven health care products that feature high deductibles and cost sharing, so members are motivated to seek out high-value providers.

These benefit designs are relatively new to the market so we are only now beginning to generate the data to determine if there have been changes in behavior. The receptivity of these plans by our customers shows an intuitive understanding and acceptance of the principle of encouraging the use of high-value providers through benefit design incentives.

To ensure that our members are empowered to navigate these new benefit designs, we have a suite of member decision-support tools. These tools are available on our member portal and offer information on both the costs and quality of care across the system. We are actively planning for the launch of our new Find-a-Doc tool on January 1, 2013, which will expand our scope and capabilities for providing timely comparative quality and cost estimate information to our members in a one-stop shopping manner.

On the provider side, as you have heard above, the AQC promotes the use of high-value providers and the AQC PCPs are encouraging consumers to make high-value choices as they exercise tighter focus on referral management. In fact, BCBSMA has witnessed shifts in referral patterns to high-value providers across our provider network and an increased focus on preventing leakage outside of a group's own system.

11. Please provide any additional comments or observations regarding premium and expenditure trends and current market dynamics you believe will help to inform our hearing and our final recommendations.

BCBSMA Response:

BCBSMA is committed to being a responsible guardian of the valuable health care premiums entrusted to us. In this regard, we have taken steps to run our business more efficiently and effectively. We launched an intensive effort to reduce our administrative costs and shrink the ten cents of every premium dollar it takes to run our business. This effort is centered on finding new efficiencies that will enable us to continue to fulfill our broader mission to our members, customers, and the community.

While these savings are important, we note that they only make a small dent in reducing the overall health care cost trend. That is because administrative costs make up only a small fraction of overall health care costs. On the other hand, medical costs, including hospital costs, professional physician costs, ancillary provider costs and pharmacy make up fully 90 percent of every dollar of premium.

The real opportunity to lower health care costs is by working aggressively to lower medical costs. The solution to addressing affordability in health care must address the true cost drivers, which include increases in the cost per service, the shift from less expensive sites of service to more expensive sites of service, increases in the utilization and intensity of services.

Many experts believe that a large portion, up to 30%, of our health care dollars is wasted. This unnecessary spending could be eliminated without reducing the quality in care

received by consumers. This wasteful spending must be addressed moving forward as we consider ways to improve how care is administered, managed, and delivered in the Commonwealth. Global payment models, like the AQC, are a way to start addressing this systemic waste.

The AQC contract model is an important component of a needed overall strategy to align payment reform, performance measurement, provider and member incentives, and increased transparency of cost and quality information to achieve the twin goals of improving the quality and affordability of health care for our members, providers and employers. BCBSMA is interested in advancing this model, along with other solutions.

It should be kept in mind that solutions take time and change will not happen over night. BCBSMA believes that with all stakeholders working together towards a solution, we can reach our cost containment goals over time.

Additional cost drivers that we believe should be examined in subsequent years are:

- Overuse of medical services: Examples include increased rates of hospital admissions and emergency room visits for avoidable or ambulatory sensitive conditions, preventable readmissions, and increased use of orthopedic procedures related to hips, knees and backs.

- Regulatory and legislative actions that impact costs and trends, like mandates and assessments on insurers. Examples of recently implemented mandates that resulted in increased costs are the vaccine assessments on a state level and the PCORI Federal assessment/tax, as well as the expansion of women's preventive services at no cost share.

- Restricting non-network charges to address the significantly higher reimbursement rates paid to providers that chose not to participate in a health plan's provider network. Out-of-network providers charge rates as much as 3 to 5 times higher than in-network providers. We estimate that the use of out-of-network providers by our members adds as much as $80 million annually in unnecessary health care spending for our customers.

- Strengthening the determination of need processes to limit supply growth.

- Cost shifting from public to private payers and the impact on commercial insured medical costs.

- Environmental factors including, but not limited to, pandemics and the economic downturn.

Attorney General Questions

1. Please submit a summary table showing your actual (or, for future dates, projected) premium trend for each year 2009 to 2013, with detail on how much annual trend resulted from (or that you project will result from) changes in administrative costs, reserve practices, and the following components of medical trend: (1) unit price, (2) utilization, (3) provider mix, (4) service mix, (5) plan design (e.g., benefit buy down), and (6) all other factors, such as member demographics. Please explain and submit supporting documents that show your analysis of the key factors driving the changes in your medical trend components.

BCBSMA Response:

Please see attached Exhibit B and Exhibit B.1

2. Please submit a summary table showing your total membership as of December 31 of each year 2008 to 2011, broken out by:
   a. Market segment (Medicare, Medicaid, other government, commercial large group, commercial small group, and commercial individual)
   b. Membership whose care is reimbursed through a risk contract, by market segment (contracts that incorporate a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged to a provider, excluding contracts that do not subject the provider to any "downside" risk; hereafter "risk contracts")
   c. Within your commercial large group, commercial small group, and commercial individual membership, by Product line (fully-insured HMO/POS, self-insured HMO/POS, fully-insured PPO/indemnity, self-insured PPO/indemnity)

BCBSMA Response:

Please see attached Exhibit C.

3. To the extent your membership in PPO and self-insured products has increased since 2005, please explain and submit supporting documents that show your understanding of the reasons underlying this growth.

BCBSMA Response:

Membership in BCBSMA PPO products has increased annually since 2005. Membership under all BCBSMA ASC products increased annually from 2005 through 2008, and has been stable since 2008. A key factor in the growth of PPO and ASC products has been an increase

in large multistate accounts. Multistate accounts seek consistency in benefits across employee populations, which is generally more easily achieved on a self-funded basis and through a PPO product. For this reason, multistate accounts are frequently both PPO and self-insured. The increase in these accounts at BCBSMA has driven growth in PPO and ASC product membership during the period.

4. Please explain and submit supporting documents that show the status of any plans to pay your network providers through risk contracts for care they provide to your PPO members.

BCBSMA Response:

As we continue to sign new AQC agreements with Massachusetts providers, they have a new imperative to align their internal operations across all patients and payers. Providers are eager to broaden the set of patients for whom they assume accountability for quality and cost. We are focused on building the AQC in two key ways:

- **Potential PPO pilot:** Global payment is a natural fit for HMO because the PCP is the single coordinator responsible for a member's continuum of care. No such link exists in the PPO design. We are exploring a potential pilot of the AQC model with Preferred Provider Organization (PPO) products using either an attribution-based or "physician of choice" method (or both) to identify members' primary physicians. We are also working with the Blue Cross Blue Shield Association to influence their payment reform strategy nationally.

- **Accountable Care Organization (ACO) demonstrations:** Some, but not all, of the provider groups participating in the AQC define themselves as ACOs. We are supporting AQC providers to participate in similar payment arrangements with other payers, namely Medicare and Medicaid. CMS' Center for Innovation recently named five provider systems in Massachusetts as Pioneer ACOs. The Pioneer model is both analogous to and synergistic with the AQC model—it is a shared savings global budget tied to quality and patient outcomes. Participation in the Pioneer pilot from CMS and the Blue Cross Blue Shield of Massachusetts AQC will allow the provider groups to not only align operationally by having a consistent payment model, but also to apply strategies and best practices for coordinating care learned in the AQC to the Medicare population.

5. Please describe your models for risk contracting since 2008. Include, for example, the structure and elements of such contracts, the role of any payments for other than medical services, the role of any trend factors or growth caps, the level of attachment points or types of carve-outs that apply to your risk budgets, and insurance product populations to which your risk contracts apply.

BCBSMA Response:

In 2009, BCBSMA introduced the AQC in an effort to moderate the unsustainable rate of increase in health care costs and improve the quality of patient care and health outcomes. Hospitals and physicians who enter into the AQC agree to take responsibility for the full continuum of care received by their patients —including the cost and quality of care— regardless of where the care is provided. The model combines a per-patient global budget with significant performance incentives based on nationally endorsed quality measures over a five-year period.

Although the AQC and its global budget has some likeness to fixed payment or capitation models of the past, the AQC specifically addresses the most important limitations of historical capitation programs. In particular, the AQC incorporates significant financial incentives that encourage physicians and hospitals to meet high standards on a broad set of quality and outcome measures. Earlier efforts at fixed payments did not include such incentives – largely because the measures did not yet exist. In addition, starting budgets for organizations in the AQC are based specifically on each organization's historical rate of spending for its patient population and adjusted for changes in that population throughout the contract term. In contrast, previous fixed payment models set budgets based on regional norms or averages, and did not account for differences in resources required for physicians caring for sicker or needier patients.

AQC contracts are generally five-year agreements, in contrast to national and historical norms of one-year fixed payment arrangements. The five-year AQC time period enables physicians and hospitals to plan for use of health care services over the life of the contract. Finally, the AQC put in place several features to mitigate financial risk for the groups, including a requirement that all groups carry reinsurance for high-cost cases (i.e., covers 70 to 90 percent of cost if medical expenditures exceed a threshold, such as $100,000), flexibility in the AQC model with respect to the degree of financial risk-sharing assumed by the provider organization based on performance on established quality metrics, and a budget trend anchored to network trend to account for network-wide changes beyond the providers' control.

Another distinguishing feature of the AQC is the ongoing data and information support provided by BCBSMA to the AQC groups. The broad set of data and reports – some daily, others monthly, quarterly, biannually and annually – is designed to support physicians' success at managing to both the quality and efficiency incentives of the AQC model.

6. Please explain and submit supporting documents that show how you quantify, and adjust, the amount of risk being shifted to providers in your network, including risk on self-insured as well as fully-insured plans. Include in your response any distinction you make between performance and insurance risk, and any adjustment you make for risk due to socioeconomic factors.

BCBSMA Response:

There are many factors that are evaluated through the course of negotiations with providers. With provider groups that are actively engaged in discussions and willing to explore a risk based contract model, factors that need to be reviewed include, but are not limited to, the groups' size, experience with risk arrangements, solvency, and infrastructure to effectively manage under a risk arrangement. These factors provide guidance to BCBSMA in negotiating the level of risk we are willing to shift to the provider groups.

Based on this analysis and discussion, several contract elements are used to vary the level and type of risk assumed by the provider. Some of the key elements include: overall risk share percentage, caps on the overall financial exposure, health status adjustments, and catastrophic claim adjustments. The overall goal is provide a meaningful incentive that focuses on factors of total cost within a provider's control and to limit factors outside that control or the impact of random variation.

BCBSMA developed the AQC in order to generate a responsible level of risk sharing between BCBSMA and providers. Risk sharing is tailored for individual providers using tools such as:

- Health Status Adjustment
- Minimum population size
- Risk Sharing (BCBSMA shares in the risk with providers)
- Risk Limits (typically BCBSMA is responsible for large losses on individual claims or across populations)
- Reinsurance
- Adjustment to global payment to accommodate added costs due to coverage mandates or higher than anticipated unit cost increases for referral providers

Even in an AQC, BCBSMA always remains the ultimate risk bearing entity, and as such, we are required to keep a certain level of statutory reserves per the DOI and NAIC standards related to risk based capital calculations.
BCBSMA also includes numerous features in the AQC contracts to protect providers from accumulating a large deficit if expenses are outpacing budget targets. These contract features include:

- Interim settlement calculations to minimize cash flow volatility
- Claim withhold features both on physician and facility claims
- Physician and hospital fee for service claim offset to recoup unpaid deficits
- Quality and infrastructure payment offset to recoup unpaid deficits

The combination of all these features provides sufficient protections so that unpaid deficits are covered without requiring additional provider reserves.

7. Please explain and submit supporting documents that show how you evaluate the capacity of a provider to participate in a risk contract, including but not limited to factors such as the provider's size, solvency, organizational infrastructure, historic experience with risk contracts, and your approach to risk adjustment.

BCBSMA Response:

As BCBSMA enters into risk arrangements with provider groups the negotiations include discussions around withhold values, solvency, infrastructure, and prior risk experience. These discussions are intended to help determine a provider group's ability to absorb risk.

With a robust provider network across the state BCBSMA has often had a pre-existing contractual relationship with the organization looking to transition to a risk based model. In reviewing that historic relationship, BCBSMA can evaluate past performance on incentive programs with lower levels of risk to gauge the appropriateness of a risk model. In addition, BCBSMA often looks to the organization's infrastructure to assess the level of alignment across a group's constituency. Past experience has indicated that groups with strong infrastructure, analytic capabilities, and strong clinical leadership are able to manage within the constructs of a risk arrangement.

There are several factors that may come into play through these discussions that enable us to adjust the risk levels to maintain the focus on cost and quality while ensuring the applicability of a risk-based model for a specific provider group. Examples of these factors may be the level of risk sharing both in a surplus and a deficit scenario, the presence of withholds, and possible caps on surplus and/or deficit levels. Adjusting these factors can minimize the potential deficit levels or anticipate possible deficit expenses while encouraging behavioral changes that drive quality, efficiency and ultimately success in a risk arrangement.

As noted in Question 6, BCBSMA always remains the ultimate risk bearing entity. BCBSMA also includes numerous features in the AQC contracts to protect providers from accumulating a large deficit if expenses are outpacing budget targets. These contract features include:

- Interim settlement calculations to minimize cash flow volatility
- Claim withhold features both on physician and facility claims
- Physician and hospital fee for service claim offset to recoup unpaid deficits
- Quality and infrastructure payment offset to recoup unpaid deficits

The combination of all these features provides sufficient protections so that unpaid deficits are covered without requiring additional provider reserves.

8. Please explain and submit supporting documents that show (a) for each year 2009 to present, the percent variation in the total health status adjusted per member per month amount you

pay to providers on their risk contract business (including any self-insured business included in your risk contracts, and all forms of payments, whether claims-based or otherwise); and (b) the factors that explain the full extent of such variation.

BCBSMA Response:

a) BCBSMA looked at the final 2009 TME and completed preliminary 2010 TME DHCFP submission for commercial full claims only. The list was them filtered down to risk groups, including upside only models. For any group whose TME was within the 90% confidence interval around 1.00, we replaced their calculated TME factor with 1.00. In other words, if the calculated result was not statistically different than average, we used average for these calculations.

Of this filtered list, we measured variation in 3 ways: min to max range, 10^{th} to 90^{th} percentile range, and interquartile range.

2009 metrics were: 42%, 19%, 11%

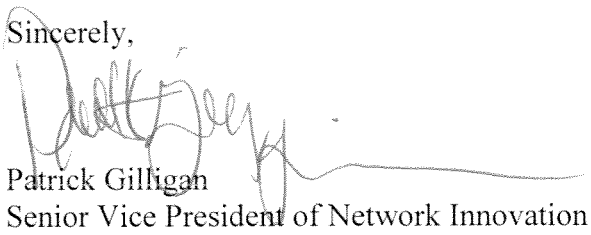
2010 metrics were: 30%, 20%, 11%

b) As noted in the responses above, BCBSMA expects some amount of variation in health-status adjusted TME among groups. Through the contract negotiation process, a larger organization is able to use its leverage on health plans due to the significant impact that its departure from the provider network would have on current insured members. This potential disruption, and the resulting underlying fee-for-service prices, becomes one factor that can impact TME. This variation can also be attributable to additional factors such as: type of risk contract, geography of the provider and alternatives in the area, socioeconomic factors of patient panels, referral patterns, availability of servicing providers, health status of the patients, effectiveness in managing patient care, high concentration of members living in urban areas and in these providers' service area, and variations in cost of living across the state.

End of Responses

I affirm that the facts contained in the preceding response are true to the best of my knowledge. This document is signed under the penalties of perjury. I have relied on others in the company for information on matters not within my personal knowledge and believe that facts stated with respect to such matters are true.

Sincerely,



Patrick Gilligan
Senior Vice President of Network Innovation & Management